Whereas individuals who sign the Birmingham Pledge give evidence of their commitment to its message;

Whereas more than 70,000 people have signed the Birmingham Pledge, including the President, Members of Congress, Governors, State legislators, mayors, county commissioners, city council members, and other persons around the world;

Whereas the Birmingham Pledge has achieved national and international recognition;

Whereas efforts to obtain signatories to the Birmingham Pledge are being organized and conducted in communities around the world;

Whereas every Birmingham Pledge signed and returned to Birmingham is recorded at the Birmingham Civil Rights Institute, Birmingham, Alabama, as a permanent testament to racial reconciliation, peace, and harmony; and

Whereas the Birmingham Pledge, the motto for which is ''Sign It, Live It'', is a powerful tool for facilitating dialogue on the Nation's diversity and the need for people to take personal steps to achieve racial harmony and tolerance in communities: Now, therefore, be it

Mr. SESSIONS. Mr. President, I rise today to offer an amendment in the nature of a substitute to H.J. Res. 102, recognizing the ''Birmingham Pledge'' and its author, Birmingham attorney James E. Rotch, for the contributions it and he have made to healing wounds of racial prejudice that still, unfortunately, divide segments of our society. The Birmingham Pledge is a powerful declaration that has had a profound impact on those who have heard or seen it. It uses words of conviction and purpose that promote racial harmony by helping people communicate about racial issues in a positive way and by encouraging people to make a commitment to racial harmony. By affixing our signatures to the message conveyed by these words, we are, in effect, saying to the world that we stand for freedom and equality for all, regardless of race or color. Further, we are saying that we will not tolerate discrimination leveled at anyone simply because of their race or color. The words of the Pledge are as follows:

I believe that every person has worth as an individual. I believe that every person is entitled to dignity and respect, regardless of race or color. I believe that every thought and every act of racial prejudice is harmful; if it is in my thought or act, then it is harmful to me as well as to others. Therefore, from this day forward I will strive daily to eliminate racial prejudice from my thoughts and actions. I will discourage racial prejudice by others at every opportunity. I will treat all people with dignity and respect; and I will strive to honor this pledge, knowing that the world will be a better place because of my effort.

These words do not reflect any new science or ground-breaking theory, instead they reflect the time-honored principles, not always followed, that have made this country the greatest example of individual liberty and freedom the world has ever known.

The words of the Birmingham Pledge are reflective of those used by Thomas Jefferson in penning the Declaration of Independence so may years ago. Jefferson wrote that ''all Men are created equal, [and] that they are endowed by their Creator with certain unalienable Rights.'' That language is clear. Thousands of citizens in Birmingham and Alabama and throughout this country and the world have recommitted themselves to these principles, and by offering this Pledge to the rest of the country, we ask everyone else to be rededicated to them, too. By signing this pledge, people make an outward showing of that commitment. Again, that is why I, on behalf of my constituents, offer this Joint Resolution. In addition to calling us to our uniquely American heritage, the words of the Birmingham Pledge also recognize Birmingham's unfortunate history as a site of significant civil rights confrontation. The Pledge conveys, as does the city's political and economic reality, that Birmingham has moved forward from that difficult time in its history to a more complete embrace of the principles embodied in this Pledge. Indeed, the city has experienced an astonishing measure of social, political, and economic progress in recent years.

More than 70,000 people around the world have seen the merit of the Birmingham Pledge and signed it because they thought it was the right thing to do. Those signing it include the President, Members of Congress, Governors, state legislators, mayors, county commissioners, city council members, clergymen, students, and the list goes on. The point is, a broad cross-section of our society has embraced the high principles conveyed in the Birmingham Pledge because they see it as a powerful tool to facilitate dialogue on racial issues and additionally as a way for people to take personal steps to achieve racial harmony and tolerance in the communities in which they live. This Resolution simply recognizes the good work that the Birmingham Pledge has already accomplished, and the potential it has for further progress in this important area of our national and international life. In order to increase awareness of the Birmingham Pledge and to further its message, this resolution calls for the establishment of a National Birmingham Pledge Week. Setting aside such a period of time to further the message of the Birmingham Pledge and to celebrate the marked progress we have made in the area of racial harmony would be a fitting way to recognize the influence the Pledge is having on race relations in communities all across America and around the world.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the amendment to the joint resolution be agreed to, and the joint resolution, as amended, be read the third time and passed, the amendment to the preamble and the preamble, as amended, be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the joint resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 4347) was agreed to.

The joint resolution (H.J. Res. 102), as amended, was read the third time and passed.

The amendment to the preamble was agreed to.

The preamble, as amended, was agreed to.

## CORRECTING ENROLLMENT OF THE BILL S. 1474

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Con. Res. 156, submitted by Senator MURKOWSKI.

The PRESIDING OFFICER. The clerk will report the concurrent resolution by title.

The legislative clerk read as follows:

A concurrent resolution (S. Con. Res. 156) to make a correction in the enrollment of the bill S. 1474.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the resolution be agreed to and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (S. Con. Res. 156) was agreed to, as follows:

S. CON. RES. 156

*Resolved by the Senate (the House of Representatives concurring),* That, in the enrollment of the bill (S. 1474) providing for the conveyance of the Palmetto Bend project to the State of Texas, the Secretary of the Senate shall make the following correction:

In section 7(a), insert ''not'' after ''shall''.

## MINORITY HEALTH AND HEALTH DISPARITIES RESEARCH AND EDUCATION ACT OF 2000

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the Health Committee be discharged from further consideration of S. 1880, and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1880) to amend the Public Health Service Act to improve the health of minority individuals.

There being no objection, the Senate proceeded to consider the bill.

AMENDMENT NO. 4349

Mr. BROWNBACK. Mr. President, Senator FRIST has a substitute amendment at the desk for himself and others.

The PRESIDING OFFICER. The clerk will report.

The clerk read as follows:

The Senator from Kansas (Mr. BROWNBACK) for Mr. FRIST, for himself, Mr. KENNEDY, Mr. JEFFORDS, Mr. DODD, Mr. DEWINE, Ms. MIKULSKI, Mr. ENZI, Mr. WELLSTONE, Mr. HUTCHINSON, Mrs. MURRAY, Ms. COLLINS, Mr. AKAKA, Mr. BOND, Mr. LAUTENBERG, Mr.

HATCH, Mr. CLELAND, and Mr. SESSIONS, proposes an amendment numbered 4349.

The PRESIDING OFFICER. Without objection, reading of the amendment is dispensed with.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. FRIST. Mr. President. Every day, through personal experience or the news, we are reminded of the tremendous scientific advances that have been made in medicine; but unfortunately, millions of Americans still experience serious disparities in health outcomes as a result of ethnicity, race, gender, or a lack of access to health care services.

Recent studies have demonstrated that minority populations, in addition to having lower rates of health care access, exhibit poorer health outcomes and may have higher rates of HIV/AIDS, diabetes, infant mortality, death from cancer and heart disease, and other health problems. For example, when compared to whites, the mortality rate for prostate cancer is nearly twice that for black men; and while African Americans make up only 13 percent of our nations's population, they represented 49 percent of AIDS deaths in 1998. Further, compared to whites, the prevalence of diabetes in Hispanic individuals is nearly double. In my home state of Tennessee, African Americans have an infant mortality rate nearly three times that of white Tennesseans, and Tennessee's African Americans suffer from heart disease at one and a half times that rate of whites and are twice as likely to suffer a stroke.

The Jackson Sun recently published an investigative report, ''What's Killing Us?: The Color of Death 10 Years Later,'' which analyzes health data specific to West Tennessee. The report highlighted that, ''[African Americans] in West Tennessee die at a much higher rate—370 percent higher for hypertension for example—than whites with the same diseases,'' and made it clear that we have failed to close the gap between death rates for black and white citizens over the last ten years. West Tennessee is a snapshot of what is happening around the country, and the lessons apply broadly. The report provides key lessons to improve health that are applicable to all Americans including the need for targeted research, improved education and public awareness, increased prevention measures, and better access to care.

However, health disparities are not limited to minority communities. Medically underserved populations located in rural Appalachia, which include significant portions of my home state of Tennessee, exhibit health disparities consistent with minority populations. In rural Appalachia, where only one doctor exists for every 1,025 patients, white males between 35 and 64 are 19 percent more likely to die of heart disease than their counterparts elsewhere in the country, and white Appalachian women are 21 percent more likely to die of heart disease. Moreover, barriers to care are undermining thee health of many communities, including rural areas where poverty and the lack of a health care infrastructure often inhibit the ability to prevent or treat health care conditions.

In order to address the issue of health disparities, in June of this year the National Institutes of Health (NIH) announced that it began the administrative process to elevate the current NIH Office of Research on Minority Health to a center. In July, I held a Public Health Subcommittee hearing, ''Health Disparities: Bridging the Gap,'' to focus on how to address minority health disparities and what measures we should take to improve minority health.

During this hearing, the Subcommittee examined health care disparities among minorities, rural and underserved populations, and women. Witnesses ranging from the Administration to experts representing the minority and underserved communities testified that a Center on Minority Health and Health Disparities is needed to focus national attention on this unrelenting problem. My friend and fellow Tennessean, Dr. John Maupin, President of Meharry Medical College of Nashville, said it best when he testified that ''ethnic minority and medically underserved populations continue to suffer disproportionately from virtually every disease and we can no longer sit idly by without addressing this national crisis.''

Today, I am pleased to introduce the Minority Health and Health Disparities Research and Education Act of 2000, with Senators KENNEDY and JEFFORDS. The Minority Health and Health Disparities Research and Education Act will expand research and education for the biomedical, behavioral, economic, institutional, and environmental factors contributing to health disparities in minority and medically underserved populations.

This legislation establishes a National Center on Minority Health and Health Disparities at NIH; a grant program through the new Center to further biomedical and behavioral research, education, and training; an endowment program to facilitate minority and other health disparities research at centers of excellence; and an extramural loan repayment program to train members of minority or other health disparities populations as biomedical research professionals.

This bill also directs the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research to identify populations for which there is a significant disparity in the quality, outcomes, cost, or use of health care services or access, as well as the causes and barriers to reducing health disparities. Additionally, AHRQ is able to identify, test, and evaluate strategies for reducing or eliminating health disparities; develop measures and tools for the assessment and improvement of the outcomes, quality, and appropriateness of health care services; and increase the number of researchers who are members of health disparity populations, or the health services research capacity of institutions that train such researchers.

Furthermore, this Act provides resources under the Health Resources and Services Administration for research and demonstration projects for the training and education of health professionals in reducing disparities in health care outcomes. A national campaign to inform the public and a plan for the dissemination of information and findings under all Titles of the Act is also established under the bill.

Health disparities may be the result of many factors, including limited access to prevention and treatment services, poverty and socioeconomic factors, exposure to environmental toxins, and even cultural factors. Turning our back on these disparities would be a national failure. Every Tennessean and every American deserves the best quality of health regardless of their race, ethnicity, sex, or where they live. With the concerted efforts of those supporting this bill, I'm certain that we can take the necessary steps to reverse our nation's health disparities.

I am pleased that the Minority Health and Health Disparities Research and Education Act is supported by Meharry Medical College in Nashville, Tennessee; East Tennessee State University (ETSU) in Johnson City, Tennessee; Morehouse School of Medicine in Atlanta, Georgia; and the Association of Minority Health Professions Schools. Dr. Ronald Franks of ETSU wrote of his support for this legislation because it identifies ''health populations as a priority in the nation's health agenda and the recognition of the health disparities in the Appalachian region.''

Mr. President, I would like to express my gratitude to Dr. John Maupin of Meharry Medical College, and Dr. Ronald Franks and Dr. Bruce Behringer of East Tennessee State University for their dedication to helping the minority and medically underserved populations in Tennessee and for their counsel and assistance on this legislation. I would also like to thank my colleagues for their work and dedication to this issue, and I look forward to the enactment of the bill this year.

Mr. KENNEDY. Mr. President, I strongly support passage of the Minority Health and Health Disparities Research and Education Act of 2000. I commend Senator FRIST for his leadership on the issue of health disparities in our minority and underserved communities. I also commend the many Senators on both sides of the aisle who worked hard to ensure that the principles of equal justice and opportunity apply to health care. Health care

should be a basic right. With our current economic prosperity and the extraordinary recent advances in medicine, we should be able to guarantee that right to all Americans.

The extraordinary advances in health care in recent decades have not been shared by all our citizens. Minority communities suffer disproportionately from higher rates of death from cancer, stroke, and heart disease, as well as from higher rates of HIV/AIDS, diabetes, and other severe health problems. Africa American men who contract prostate cancer are more than twice as likely to die from it as white men. Vietnamese American women are five times more likely than white women to contract cervical cancer. Hispanic women are twice as likely to contract cervical cancer. Native Hawaiian men are 13 percent more likely to contract lung cancer. Alaskan Native women are 72 percent more likely to contract colon cancer and rectal cancer. In addition, African Americans and Hispanic Americans are more likely to be diagnosed with cancer after the disease has reached an advanced stage. For African Americans, the result is a 35 percent higher death rate.

The reality of poverty clearly affects the nation's health. Nearly 20 million white Americans live below the poverty line and many live in rural areas such as Appalachia, where 46 percent of counties are designated as health professions shortage areas and high rates of poverty contribute to health disparity outcomes. The lack of a health care facilities or benefits often means poor health care and often a poor prognosis for what might have been a preventable or curable condition. In the Appalachia regions of Kentucky, Tennessee, and West Virginia, the rates of the five top causes of death in the U.S. all exceeded the national, average in 1997. Lack of availability and access to health care for poor and underserved regions often goes hand in hand with higher morbidity and mortality rates. Higher rates of heart disease in white males between the ages of 35 and 64 and cervical cancer in white females are also found in Appalachia. We must find better answers to identify and overcome the barriers to care that lead to dire outcomes in underserved communities.

While we have continued to make progress in the reduction of child poverty, child mortality, teenage pregnancy, and juvenile violence, we continue to see wide disparities by race and income, with communities of color and those in poverty lagging behind others. Infant mortality rate has declined nationally from 10.9 infant deaths for every 1,000 live births in 1983 to 7.2 in 1998. But among African Americans, the rate is 13.7—more than twice the rate of any other group. In addition, far too many people across this nation lack the health insurance that is necessary for access to basic health care. Over one-third of Hispanic Americans are uninsured, the highest rate among all ethnic groups and two and a half time the rate of 14% for whites. Nearly one-fourth of African Americans, and about one-fifth of Asian Americans are also uninsured.

In Massachusetts, significant progress has been made in improving the overall health status and access to health care. We are one of a handful of states in the country to devote the tobacco settlement money entirely to health care. Yet our significant commitment to health care is not translating into equal access or improved health status for all of our citizens. Health status differs by racial/ethnic group and by income group and the differences are reflected in the alarming discrepancy in mortality rates. The infant mortality rate for African-Americans is 11.7—over twice as high as the overall statewide rate of 5.3.

The same pattern exists for the HIV/AIDS-related mortality rate, which is more than six times greater for African-Americans and more than four times greater for Hispanics. African American women are more likely to lose their lives to breast cancer, and nearly six times a many Asian-American women and nearly two times as many Hispanic women have never taken a Pap test, which is essential in detection cervical cancer. Clearly, too many citizens are not benefitting from the advances made in science, medicine, and the economy.

The Minority Health and Health Disparities Research and Education Act addresses the biomedical, behavioral, economic, institutional, and environmental factors that have caused health disparities in communities of color and in undeserved communities around our nation. It provides needed resources for research, data collection, medical education, and public awareness, in order to understand the root causes of diseases and poor health outcomes and to develop strategies to meet the health needs of these vulnerable communities. Each of these aspects has an important role to play in the reduction and eventual elimination of the unacceptable disparities that now exist.

Title I of the bill establishes a Center for Research on Minority Health and Health Disparities at the National Institutes of Health. It also provides resources to educational institutions to train minority individuals as biomedical research professionals.

Title II focuses on identifying, evaluating, and disseminating information on the factors that contribute to health disparities.

Title III addresses the critical need for trained and culturally competent health care professionals by providing resources to develop effective educational support.

Title IV enhances the collection of data on race and ethnicity to determine what steps the federal government should take to ensure that all necessary information is collected.

Title V provides funding for a public awareness and information campaign to inform minority communities of the health conditions that are affecting them disproportionately and of the programs and services available to them.

Passage of the Minority Health and Health Disparities Research and Education Act demonstrates our strong commitment a healthier future for all our citizens. America has the resources to accomplish this goal and I urge the Senate to achieve it.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the amendment be agreed to, the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 4349) was agreed to.

The bill (S. 1880), as amended, was passed.

## THE AMERICAN MUSEUM OF SCIENCE AND ENERGY

Mr. BROWNBACK. I ask unanimous consent that the Senate proceed to the consideration of H.R. 4940, which is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 4940) to designate the museum operated by the Secretary of Energy at Oak Ridge, Tennessee, as the American Museum of Science and Energy, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

AMENDMENT NO. 4348

Mr. BROWNBACK. Mr. President, Senators MURKOWSKI, FRIST, and BINGAMAN have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas (Mr. BROWNBACK), for Mr. MURKOWSKI, for himself, Mr. FRIST, and Mr. BINGAMAN, proposes an amendment numbered 4348.

The PRESIDING OFFICER. Without objection, reading of the amendment is dispensed with.

The amendment is as follows:

**"SECTION 1. DESIGNATION OF AMERICAN MUSEUM OF SCIENCE AND ENERGY.**

''(a) IN GENERAL.—The Museum—

''(1) is designated as the 'American Museum of Science and Energy'; and

''(2) shall be the official museum of science and energy of the United States.

''(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the Museum is deemed to be a reference to the 'American Museum of Science and Energy'.

''(c) PROPERTY OF THE UNITED STATES.—

''(1) IN GENERAL.—The name 'American Museum of Science and Energy' is declared the property of the United States.

''(2) USE.—The Museum shall have the sole right throughout the United States and its possessions to have and use the name 'American Museum of Science and Energy'.

''(3) EFFECT ON OTHER RIGHTS.—This subsection shall not be construed to conflict or interfere with established or vested rights.